The Major Points

Medicare’s cost is based on ICD-9-CM diagnostic codes, not CPT® procedural codes.

Federal regulations require Medicare and its agents to review medical records in order to validate and avoid both underpayments and overpayments.

It is important for the physician’s office to fully code each encounter; the claim should report the ICD-9-CM code of every diagnosis that was addressed, and should only report codes of diagnoses that were actively addressed.

Contributory (co-morbid) conditions should be reported if they impact the care and are therefore addressed at the visit, but not if the condition is inactive or immaterial.

It should be obvious from the medical record entry associated with the claim that all reported diagnoses were addressed and that all diagnoses that were addressed were reported.

CMS Data Validation

Data Validation ensures the integrity and accuracy of risk-adjusted payment. It is the process of verifying that the diagnosis codes submitted by the Medicare Advantage organization are supported by the medical record documentation for a member.

Medicare Advantage plans are selected for data validation audits annually.

It is important for physicians and their office staff to be aware of risk adjustment data validation activities because medical record documentation may be requested by the Medicare Advantage organization. As previously stressed, accurate risk-adjusted payment relies on the diagnostic coding derived from the member’s medical record.

For more information related to risk adjustment, visit the Centers for Medicare & Medicaid Services Web site at http://csscoperations.com/.

CPT® is a registered trademark of the American Medical Association

**What is Risk Adjustment?**
Risk Adjustment is the process by which the Centers for Medicare & Medicaid Services (CMS) reimburses Medicare Advantage plans, such as BlueCross BlueShield of Tennessee, based on the health status of their members. Risk adjustment was implemented to pay Medicare Advantage organizations more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (age and gender) as well as health status.

**Risk Adjustment Implementation**
As a part of risk adjustment implementation, CMS initially collected hospital inpatient diagnoses for determining payment to Medicare Advantage plans. In 2000, Congress mandated a change to include ambulatory data. This change took place gradually, with full implementation in 2007. CMS selected a payment model that included diagnostic data reported from hospital inpatient, physician, and hospital outpatient settings, the CMS-Hierarchical Condition Category (CMS-HCC) payment model.

**Physician’s Role**
- Physician data is critical for accurate risk adjustment
- Physicians are the largest source of ambulatory data for the risk adjustment model
- CMS-HCC model relies on ICD-9-CM coding specificity
- Risk adjustment uses ICD-9-CM diagnosis codes not CPT® procedure codes

**Why is Medical Record Documentation Important for Risk Adjustment?**
- Accurate risk adjusted payment relies on complete medical record documentation and diagnostic coding.
- CMS conducts risk adjustment data validation by medical record review.
- Specificity of the ICD-9 diagnosis coding is substantiated by the medical record.

**Importance of ICD-9-CM Diagnostic Coding**
- ICD-9-CM is the official diagnosis code set for Medicare.
- ICD-9-CM codes are used for risk adjusted payment.
- Medical record documentation dictates what code is assigned.
- Appropriate coding requires use of the most specific code available.

**Medical Record Documentation**
- Documentation should be clear, concise, consistent, complete and legible.
- Document coexisting conditions at least annually
- Use standard abbreviations
- Develop a problem list
- Identify patient and date on each page of the record
- Authenticate the record with signature and credentials

**Requests for Medical Records**
Health plans perform medical record reviews to identify additional conditions not captured through claims or encounter data and to verify the accuracy of coding.

Under CFR 164.502 (HIPAA implementation) you are permitted to disclose the requested data for the purpose of health care operations, after you have obtained the “general consent” of the member. A general consent form should be an integral part of your medical record file.

Medical Records can be mailed or faxed to:
BlueCross BlueShield of Tennessee
Attn: RAPS Department
P.O. Box 180205
Chattanooga, TN 37401-9943
Fax: 1-877-922-2963